

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.			Length of stay in 1b		c. CITY OR TOWN ST. LOUIS, MO		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hosp. #1			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2203 CHOUTEAU		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) JOYCE ANN Wagner Baby Girl				Middle WAGNER Last		4. DATE OF DEATH Month Sept Day II Year 1960	
5. SEX FEMALE		6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 9/10/60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME LLOYD JEROME				13b. MOTHER'S MAIDEN NAME THEOLA TAYLOR		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS ST. LOUIS CITY HOSP. #1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital atelectasis DUE TO (b) Prematurity DUE TO (c) 76 25							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from 9-10-60 to 9-11-60 and last saw her alive on 9-11-60 Death occurred at 12:50 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) William Donald Richardson M.D.				22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 9-11-60	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-30-60		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR ADDRESS Rowland Mortuary Svc. 4104-06 Manchester				25. DATE RECD. BY LOCAL REG. SEP 15 1960		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to co
with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.